

APPLICATION
FOR
UNITED STATES LETTERS PATENT

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FOR
METHODS FOR DECREASING BETA AMYLOID PROTEIN

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Background of the Invention

The United States government has certain rights in this invention by virtue of National Institutes of Health grant number RO1NS33325 to Bruce A. Yankner.

Alzheimer's disease (AD) is the most common cause of dementia in the aged population. The accumulation of large numbers of senile plaques containing the 40-42 amino acid amyloid β protein ($A\beta$) is a classic pathological feature of AD. Both genetic and cell biological findings suggest that the accumulation of $A\beta$ in the brain is the likely cause of AD (Yankner, B.A. (1996) Neuron 16, 921-932.; Selkoe, D.J. Science 275, 630-631 (1997)). Strong genetic evidence in support of the pathogenic role of $A\beta$ came from the observation that individuals who inherit mutations in the amyloid precursor protein almost invariably develop AD at an early age. These mutations increase the production of a long variant of the $A\beta$ peptide that forms senile plaques in the brain (Goate et al., (1991) Nature 349, 704-706). Mutations and allelic variations in other genes that cause AD, including the presenilins and apolipoprotein E, also result in increased production or deposition of the $A\beta$ peptide. Reiman, et al. (1996) N.E.J.Med. 334, 752-758, reported that in middle age, early to mid 50's, individuals who are homozygous for the Apo E4 gene have reduced glucose metabolism in the same regions of the brain as in patients with Alzheimer's disease. These findings suggest that the pathological changes in the brain associated with this gene start early. Furthermore, individuals with Down's syndrome overexpress the amyloid precursor protein, develop $A\beta$ deposits in the brain at an early age, and develop Alzheimer's disease at an early age. Finally, the $A\beta$ protein has been demonstrated to be highly toxic to nerve cells. Thus, it is widely believed that drugs which decrease the levels of $A\beta$ in the brain would prevent Alzheimer's disease.

The known genetic causes of AD can account for only a small proportion of the total number of cases of AD. Most cases of AD are sporadic and occur in the aged population. A major goal of research is the identification of environmental factors that predispose to AD that would be amenable to therapeutic measures.

It is therefore an object of the present invention to provide methods for predicting populations at risk of developing AD.

It is another object of the present invention to provide diagnostics and pharmaceuticals to decrease the production of amyloid β protein ($A\beta$), and thereby to prevent or reduce the likelihood of developing AD.

It is a further object of the present invention to provide pharmaceutical treatments to treat AD in patients' having the neuropsychiatric or diagnostic criteria for AD.

Summary of the Invention

Blood cholesterol levels are correlated with production of amyloid β protein ($A\beta$), and are predictors of populations at risk of developing AD. Methods for lowering blood cholesterol levels can be used to decrease production of $A\beta$, thereby decreasing the risk of developing AD. The same methods and compositions can also be used for treating individuals diagnosed with AD. Methods include administration of compounds which increase uptake of cholesterol by the liver, such as the administration of HMG CoA reductase inhibitors, administration of compounds which block endogenous cholesterol production, such as administration of HMG CoA reductase inhibitors, administration of compositions which prevent uptake of dietary cholesterol, and administration of combinations of any of these which are

5 effective to lower blood cholesterol levels. Methods have also been developed to predict populations at risk, based on the role of cholesterol in production of $A\beta$. For example, individuals with Apo E4 and high cholesterol, defined as a blood cholesterol level of greater than 200 mg/dl, post menopausal women with high cholesterol levels - especially those who are not taking estrogen, or individuals which high blood cholesterol levels who are not obese are all at risk of developing AD if blood cholesterol levels are not decreased. In the preferred embodiment, individuals with these risk factors are treated to lower blood cholesterol levels prior to developing any mental impairment attributable to AD, based on accepted neuropsychiatric and diagnostic criteria in clinical practice. Treatment is based on administration of one or more compositions effective to lower cholesterol blood levels at least 10%, which is believed to be sufficient to decrease production of $A\beta$.

10 Diagnostic kits based on the discovery of these risk factors include reagents for measurement of cholesterol, total lipoproteins, and/or Apo E4.

15 The examples demonstrate the use of HMG CoA reductase inhibitors to treat Alzheimer's disease. Rats fed a high cholesterol diet show increased levels of the Alzheimer's disease $A\beta$ protein in the brain. Cholesterol has been shown to increase the amount of $A\beta$ in human neurons in culture. The HMG CoA reductase inhibitors reduce cholesterol production. Several different HMG CoA reductase inhibitors, including lovastatin, simvastatin, fluvastatin, pravastatin and compactin, significantly inhibit the level of $A\beta$ production in human neuronal cultures.

Detailed Description of the Invention

I. Methods for Predicting Populations at Risk for AD

Individuals at increased risk for A β accumulation and Alzheimer's disease are those who carry a copy of the apolipoprotein E4 gene (Strittmatter et al., (1993) Proc. Natl. Acad. Sci. U.S.A. 90, 1977-1981), those with trisomy 21 (Down's syndrome) (Mann and Esiri, (1989) J. Neurol. Sci. 89, 169-179)), and individuals who carry a mutation in one of the genes that encode the amyloid precursor protein, presenilin-1 or presenilin-2 (reviewed in Yankner, 1996). In addition, individuals with a family history of Alzheimer's disease have been documented to be at increased risk of Alzheimer's disease (Farrer et al., (1989) Ann. Neurol. 25, 485-492; van Duijn et al., (1991) Int. J. Epidemiol. 20 (suppl 2). S13-S20), and could therefore benefit from prophylactic treatment with an HMG CoA reductase inhibitor.

Methods have also been developed to predict populations at risk, based on the role of cholesterol in production of A β . Several risk factors for developing AD have been identified. These include:

- (1) individuals with Apo E4 and high cholesterol, defined as a blood cholesterol level of greater than 200 mg/dl,
- (2) post menopausal women with high cholesterol, especially those who are not taking estrogen,
- (3) young individuals with high blood cholesterol levels who are not obese (age 48-65 yrs),
- (4) individuals with high blood cholesterol levels who have a family history of AD,

(5) individuals with high blood cholesterol levels who have a family history of AD, and

(6) all adult individuals with Down's syndrome.

These individuals are all at risk of developing AD if blood cholesterol levels are not decreased. In the preferred embodiment, individuals with these risk factors are treated to lower blood cholesterol levels prior to developing any mental impairment attributable to AD using accepted neuropsychiatric and diagnostic criteria for probable Alzheimer's disease (McKhahn et al. (1984) Neurology 34:939-944).

Individuals can be screened using standard blood tests for cholesterol, ApoE4, and/or total lipoprotein levels, as well as by taking a medical and family history. In addition, over the counter immunoassay tests can be used by individuals who may be at risk, so that they can seek further medical advise. These immunoassay kits can be qualitative and/or quantitative for elevated cholesterol, total lipoproteins, and Apo E4.

II. Methods of Treatment to Decrease Production of $A\beta$.

Methods for lowering blood cholesterol levels can be used to decrease production of $A\beta$, thereby decreasing the risk of developing AD. The same methods can also be used to treat patients who have already been diagnosed with AD. Methods include administration of compounds which increase uptake of cholesterol by the liver, such as the administration of HMG CoA reductase inhibitors, administration of compounds which block endogenous cholesterol production, such as administration of HMG CoA reductase inhibitors, administration of compositions which prevent uptake of dietary cholesterol, and administration of combinations of any of these which are effective to lower blood cholesterol levels.

5 The examples indicate that several different HMG CoA reductase inhibitors reduce the production of A β . HMG CoA reductase inhibitors may act to lower cholesterol at several different levels. For example, HMG CoA reductase inhibitors have been shown to lower blood cholesterol levels by upregulating lipoprotein clearance receptors in the liver (Brown and Goldstein, (1986) Science 232, 34-47). In addition, HMG CoA reductase inhibitors will directly inhibit cholesterol synthesis in neurons. Since every HMG CoA reductase inhibitor tested reduces A β production, it is anticipated that new members of this class of drugs will also inhibit A β production. Furthermore, since increased dietary cholesterol increases A β in the brain, drugs which act through other mechanisms to reduce cholesterol will also inhibit A β production.

10 Representative CoA reductase inhibitors include the statins, including lovastatin, simvastatin, compactin, fluvastatin, atorvastatin, cerivastatin, and pravastatin. These are typically administered orally.

15 Compounds which inhibit cholesterol biosynthetic enzymes, including 2,3-oxidosqualene cyclase, squalene synthase, and 7-dehydrocholesterol reductase, can also be used.

20 Representative compositions which decrease uptake of dietary cholesterol include the bile acid binding resins (cholestyramine and colestipol) and the fibrates (clofibrate). Probucol, nicotinic acid, garlic and garlic derivatives, and psyllium are also used to lower blood cholesterol levels. Probucol and the fibrates increase the metabolism of cholesterol-containing lipoproteins. The cholesterol-lowering mechanism of nicotinic acid is not understood.

25 Although the preferential route of administration of HMG CoA reductase inhibitors would be oral, the drugs could also be administered by

intravenous, subcutaneous or intramuscular routes. In some cases, direct administration into the cerebrospinal fluid may be efficacious.

III. Examples

Prior to the studies described in the following examples, the relationship between cholesterol and $A\beta$ levels in the brain was unknown. In one study, rabbits which were fed a high cholesterol diet showed increased immunocytochemical staining of brain neurons with an antibody to $A\beta$. However, this antibody was not specific for $A\beta$, and could cross-react with other metabolites of the amyloid precursor protein (Sparks, D.L. (1996) *Neurobiology of Aging*. 17, 291-299). The studies in the following examples demonstrate that: rats fed a high cholesterol diet show increased levels of the Alzheimer's disease $A\beta$ protein in the brain; cholesterol increases the amount of $A\beta$ in human neurons in culture; HMG CoA reductase inhibitors reduce cholesterol production; and several different HMG CoA reductase inhibitors, including lovastatin, simvastatin, fluvastatin, pravastatin and compactin, significantly inhibit the level of $A\beta$ production in human neuronal cultures.

Example 1: Cholesterol increases the level of $A\beta$ in human neuronal cultures.

Busciglio et al., (1993) *Proc. Nat. Acad. Sci.* 90, 2092-2096, described the production of $A\beta$ by human cortical neurons in culture. To determine whether cholesterol can affect the production of $A\beta$, primary human brain cultures were established from the cortex of 16-20 week fetal abortuses, and the neurons incubated in the absence or presence of very low density lipoprotein (VLDL), low density lipoprotein (LDL) or high density lipoprotein (HDL) particles isolated from human plasma. These lipoprotein particles are the physiological vehicles for the transport of cholesterol to

cells. The effects of the different lipoprotein particles on the levels of A β in the human cortical cultures was determined. The human cortical cultures were maintained in serum-free Dulbecco's Modified Eagle's Medium (DMEM) with N2 supplements (a serum-free supplement that supports neuronal viability). The medium was then changed to the same medium (controls) or medium supplemented with VLDL, LDL, or HDL particles. After incubation for 48-72 hours, A β was measured by immunoprecipitation of the culture medium with a polyclonal antibody to A β (B12), followed by Western blotting with a monoclonal antibody to A β (6E10). The Western blots were developed either by the enhanced chemiluminescence method or by addition of an ^{125}I -labeled secondary antibody and phosphorimager scanning. The bands corresponding to the 40 and 42 amino acid form of A β were analyzed quantitatively using a computer software program. Control human cortical cultures produced basal levels of A β . Exposure of the human cortical cultures to VLDL, LDL or HDL particles increased the levels of both the 40 and 42 amino forms of A β . These results suggest that the major classes of cholesterol-containing lipoproteins all act to increase production of A β in human neurons.

It was then determined whether lipoprotein particles containing apolipoproteins E or A1 were able to increase A β production. To address this question, synthetic lipoprotein particles containing these proteins were created. Particles containing either apolipoprotein E or A1 increased the level of A β in the human cortical cultures.

These results indicate that a variety of different cholesterol carrying lipoprotein particles can increase the production of A β in primary human neuronal cultures.

Example 2: Dietary cholesterol increases A β levels in the brain.

After establishing that cholesterol-carrying lipoprotein particles increase $A\beta$ in cultures of human neurons, it was determined whether dietary cholesterol increases the level of $A\beta$ in the brain *in vivo*. Increased dietary intake of cholesterol is known to increase circulating levels of lipoprotein particles, which in turn increases the delivery of cholesterol to cells. These experiments were performed on 20 month old rats. The rats were fed a low cholesterol diet (0.1% cholesterol) or a high cholesterol diet (5% cholesterol). After 10 weeks, the animals were sacrificed and the cortex was removed for measurement of $A\beta$ levels. $A\beta$ was assayed by immunoprecipitating cortical homogenates with the $A\beta$ antibody B12, followed by Western blotting with the commercially available $A\beta$ monoclonal antibody 4G8.

Resolution of the $A\beta$ isolated from rat cerebral cortex by electrophoretic separation on gels showed that $A\beta$ levels were significantly increased by about 50% in the group of rats fed the high cholesterol diet relative to the group of rats fed the low cholesterol diet. These findings indicate that dietary cholesterol increases the amount of $A\beta$ in the brain. It is noteworthy that the approximately 50% increase in $A\beta$ in the brain induced by a high cholesterol diet is similar to the increase in $A\beta$ which occurs in Down's syndrome, which is known to predispose to the development of Alzheimer's disease.

Example 3: HMG CoA Reductase Inhibitors Inhibit the Production of $A\beta$ by Human Neurons.

The HMG CoA reductase inhibitors have been used in humans to decrease plasma levels of cholesterol in patients at risk for heart disease. The discovery that cholesterol increases the amount of $A\beta$ in the brain led to this investigation to determine whether the HMG CoA reductase inhibitors

may be therapeutically efficacious for Alzheimer's disease by inhibiting the production of A β . Human cortical neuronal cultures were established from 18 weeks gestation normal fetal cortical tissue as described above and maintained in a culture medium comprised of DMEM containing N2 supplements. After one week, the culture medium was changed to DMEM + N2 supplements (control), or DMEM + N2 supplements + either 100 μ M lovastatin, 100 μ M simvastatin, 100 μ M compactin, 100 μ M fluvastatin, or 1 mM pravastatin. after incubation for 48 hours, the cultured cells were harvested and the levels of A β were assayed, as described above.

A β was isolated from the culture medium from human cortical neuronal cultures and resolved by electrophoresis in gels. These results demonstrate that human neurons treated with either lovastatin, simvastatin, compactin, fluvastatin or pravastatin have significantly decreased levels of A β relative to controls. These results indicate that HMG CoA reductase inhibitors decrease the production of A β by human neurons.

The finding that HMG CoA reductase inhibitors inhibit A β production by human cortical cells supports the use of this class of drugs for reducing the levels of A β in individuals with Alzheimer's disease or at risk of developing Alzheimer's disease.

Modifications and variations of the methods and compositions for prediction of the likelihood of developing AD, and for preventing and/or treating AD, will be obvious to those skilled in the art. These modifications and variations are intended to come within the scope of the appended claims.